**DEPARTMENT OF HEALTH SERVICES**
P.O.BOX 942732
SACRAMENTO, CA 94234-7320
(916) 323-1945

Dear Pharmacy Applicant:

Thank you for your recent inquiry regarding participation in the Medi-Cal program. Enclosed is the Medi-Cal provider enrollment application package you requested. Requests for additional application packages should be directed to Electronic Data Systems Corporation (EDS), the Medi-Cal fiscal intermediary, at (800) 541-5555.

Instructions for completion of these documents are included on the forms. Please read the instructions carefully. If after reading the instructions you have questions regarding the completion of the application, disclosure statement and/or provider agreement, you may call the Provider Enrollment Branch at (916) 323-1945 between the hours of 8 a.m. and 5 p.m. Application packages that are incomplete or not on Department of Health Services (Department) issued forms will be returned to you.

It is your responsibility to report to the Department any changes to information previously reported on the enrollment documents within 35 days of the change. Most changes may be reported on a Medi-Cal Supplemental application. You may request a Medi-Cal Supplemental application by contacting EDS. If, however, you are reporting a change of ownership of 50 percent or more, you must complete a new application package.

Also enclosed is a Medi-Cal Telecommunications Provider and Biller Application/Agreement. This form must be completed in order for a pharmacy to apply for a submitter number to do electronic claims submission. The submitter number for existing pharmacies is not transferable. A new submitter number must be obtained each time a new Medi-Cal pharmacy provider number is issued by the Department. If you have any questions about completing this form, please contact EDS' Computer Media Claims desk at (916) 636-1100.

For more information on the forms and the regulatory requirements for participation in the Medi-Cal program, please visit our website at www.Medi-Cal.ca.gov and click on Publications, then Provider Enrollment.

If you have any questions, please call our office at (916) 323-1945.

Provider Enrollment Branch
Payment Systems Division

Enclosures

# MEDI-CAL PHARMACY PROVIDER APPLICATION

**FOR STATE USE ONLY**

**Important:**

- Read *all* instructions before completing the application.
- Type or print clearly, in ink.
- If you must make corrections, please line through, date, and initial in ink.
- Return completed forms to: Department of Health Services
  Provider Master File Unit
  P.O. Box 942732
  Sacramento, CA 94234-7320
  (916) 323-1945

***Do not leave any questions, boxes, lines, etc. blank. Enter N/A if not applicable to you.***

Enrollment action requested (check one) | Date

- ❒ New provider
- ❒ Change of ownership—Current Medi-Cal provider number: _____
- ❒ Change of business address—Current Medi-Cal provider number: _____
- ❒ Additional business address—Current Medi-Cal provider number: _____
- ❒ Continued enrollment (Do not check this box unless you have been requested by the Department to apply for continued enrollment in the Medi-Cal program pursuant to Title 22, California Code of Regulations, Section 51000.55.) Current Medi-Cal provider number: _____

Type of entity

- ❒ Sole proprietor
- ❒ Corporation:
  Corporate number: _____
  State incorporated: _____
- ❒ Partnership
- ❒ Limited liability corporation:
  Corporate number: _____
  State incorporated: _____
- ❒ Government
- ❒ Other: _____

1. Legal name of applicant or provider (as listed with the IRS)

2. Business name, if different

3. Business telephone number ( )

Is this a fictitious business name? ❒ Yes ❒ No

If yes, list the Fictitious Business Name Statement number

Effective date

(Attach a legible copy of the recorded/stamped Fictitious Business Name Statement.)

| | City | County | State | Nine-digit ZIP code |
|---|---|---|---|---|
| 4. Business address (number, street) | | | | |
| 5. "Pay to" address (number, street, P.O. Box number) | | | | |
| 6. Mailing address (number, street, P.O. Box number) | | | | |

7. Federal Employer Identification Number (FEIN) (Attach a legible copy of the IRS form.)
____ ____ – ____ ____ ____ ____ ____ ____ ____

8. Social security number or Individual Taxpayer Identification Number (ITIN) (If Sole Proprietor not using a FEIN, you must disclose this number and attach a legible copy of the ITIN verification, if applicable.) (See Privacy Statement on page 3.)
____ ____ ____ – ____ ____ – ____ ____ ____ ____

| 9. California State Board of Pharmacy Permit number (attach a legible copy) | Expiration date | 10. Medicare billing number | 11. Seller's Permit number (attach a legible copy) |
|---|---|---|---|
| | | | |

12. Any local business license/permit numbers (attach legible copies)

13. The business days and hours of operation are: Days: _____ Hours: _____

14. Do you have a retail business open and available to the general public which meets all local laws and ordinances regarding business licensing and operations and is readily identifiable as a place in which you sell, rent, or lease durable medical equipment, incontinence medical supplies and/or medical supply items? ❒ Yes ❒ No

If no, please explain: _____

_____

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Are your equipment and/or supplies:

❒ A. In stock on the premises, or

❒ B. In a warehouse under the applicant's or provider's direct control.

If B is checked, provide the following information for the warehouse:

| Address (number, street) | City | State | ZIP code |
|---|---|---|---|
| | | | |

Who holds an ownership interest in the warehouse? (Use additional sheets if necessary.)

| Name | | Telephone number ( ) | |
|---|---|---|---|
| Address (number, street) | City | State | ZIP code |
| | | | |

15. Applicant or provider business activities include the sale, rental, and/or lease of the type of items checked below. Give the percentage of each business activity in which the applicant or provider engages in. Total the percentages at the end of this question. Percentages must total 100 percent. (Include licensure information of applicable business activities.) Please see instructions for computing percentages.

A. ❒ Prescribed drugs _____%

| Drug Enforcement Agency registration certification number | Effective/expiration dates (attach a legible copy of the certificate) | National Council for Prescription Drug Programs (NCPDP) number |
|---|---|---|
| | | |

B. ❒ Beds* ❒ Rental ❒ Sales (if the business sells AND rents beds, check both boxes.) _____%

C. ❒ Wheelchairs* _____%

*Bureau of Home Furnishings and Thermal Insulation license:

If you rent beds, your license must bear a registry number. If it does not, please call the Bureau at (916) 574-0280 for instruction. If you checked bedding and wheelchairs, you must have a Furniture and Bedding License. Any questions must be directed to the Bureau at the above number.

Furniture and Bedding or Furniture Retailer License number (attach a copy): _____

Issuance date: _____ Expiration date: _____

D. ❒ Ostomy supplies (describe): _____ _____%

E. ❒ Oxygen/oxygen therapy equipment and supplies (describe): _____ _____%

F. ❒ Urinary catheters, bags, etc. (describe): _____ _____%

G. ❒ Orthotic/prosthetic appliances (describe) _____ _____%

H. ❒ Incontinence medical supplies (describe): _____ _____%

**You must comply with Article 3.7 of the Welfare and Institutions Code. If you are not selling incontinence supplies, enter zero (0) in the percentage column.**

I. ❒ Infusion equipment and supplies (describe): _____ _____%

J. ❒ Other (describe): _____ _____%

**TOTAL** _____%

## Information On The Pharmacist-In-Charge (PIC) At The Business Location

***FOR STATE USE ONLY***

16. Print name (last) (first) (middle)

17. License number (attach a legible copy of license)

18. Driver's license or state-issued ID number and state of issuance (attach a legible copy)

19. Social security number (***Optional—see*** Privacy Statement below.)

___ ___ ___ — ___ ___ — ___ ___ ___ ___

## Information About Individual Signing This Application

20. Printed name of individual signing this application (last) (first) (middle)

21. Gender
❒ Male
❒ Female

22. Driver's license or state-issued ID number and state of issuance (attach a legible copy)

23. Date of birth

24. Social security number (***Optional***—see Privacy Statement below.)

___ ___ ___ — ___ ___ — ___ ___ ___ ___

25. **I declare under penalty of perjury under the laws of the State of California that the foregoing information in this document, in the attachments, the disclosure statement, and provider agreement are true, accurate, and complete to the best of my knowledge and belief. I declare that I have the authority to legally bind the applicant or provider.**

Signature of the person authorized to bind the applicant or provider

Title

Executed at: _____, _____ on _____
(City) (State) (Date)

**Privacy Statement**
**(Civil Code, Section 1798 et seq.)**

All information requested on the application, the disclosure statement, and the provider agreement is mandatory with the exception of the social security number for any person other than the person or entity for whom an IRS Form 1099 must be provided by the Department pursuant to 26 USC 6041. This information is required by the Department of Health Services, Payment Systems Division, by the authority of Welfare and Institutions Code, Section 14043.2(a) and Title 22, California Code of Regulations, Section 51536. The consequences of not supplying the mandatory information requested are denial of enrollment as a Medi-Cal provider and issuance of the Medi-Cal provider number or denial of continued enrollment as a provider and deactivation of all Medi-Cal provider numbers used by the provider to obtain reimbursement from the Medi-Cal program. The consequence of not supplying the voluntary social security number information requested is delay in the application process while other documentation is used to verify the information supplied. Any information provided will be used to verify eligibility to participate as a provider in the Medi-Cal program. Any information may also be provided to the State Controller's Office, the California Department of Justice, the Department of Consumer Affairs, the Department of Corporations, or other state or local agencies as appropriate, fiscal intermediaries, managed care plans, the Federal Bureau of Investigation, the Internal Revenue Service, Medicare Fiscal Intermediaries, Health Care Financing Administration, Office of the Inspector General, Medicaid, and licensing programs in other states. For more information or access to records containing your personal information maintained by this agency, contact the Chief, Payment Systems Division, Sacramento, CA, (916) 323-1945.

## INSTRUCTIONS FOR COMPLETION OF THE MEDI-CAL PHARMACY PROVIDER APPLICATION

***DO NOT USE*** correction tape, white out, etc.; highlighter pen or ink of a similar type on this form.

This form is an application for enrollment or continued enrollment as a provider in the Medi-Cal program. Applicants and providers may also need to provide additional information and documentation. Applicants may be subject to an on-site inspection prior to enrollment. Applicants or providers may be subject to unannounced visits prior to enrollment or approval in the program. In addition to the application, the attached disclosure statement and a provider agreement must also be completed for enrollment.

Omission of any information or documentation on this form or the failure to sign any of these documents may result in any of the denial actions identified in Title 22, California Code of Regulations, Section 51000.50.

Enrollment Action Requested (check one). Enter the date you are completing the application.

“New provider” means the applicant is not currently enrolled in the Medi-Cal program and would like to have a provider number issued.

“Change of ownership” means the ownership of the pharmacy has changed and a new pharmacy permit is required from the California State Board of Pharmacy pursuant to Business and Professions Code (commencing with Section 4000).

“Change of business address” means the pharmacy is currently enrolled in the Medi-Cal program and is requesting a Medi-Cal provider number for a different location.

“Additional business address” means an existing pharmacy is currently enrolled in the Medi-Cal program and is requesting a Medi-Cal provider number for an additional business location.

“Continued enrollment” means the applicant is currently enrolled as a Medi-Cal provider and has been requested to apply for continued participation in the Medi-Cal program. (See Title 22, California Code of Regulations, Section 51000.55.) List curent Medi-Cal provider number.

“Type of Entity”: Check the box which applies to your business structure. Your corporate status will be verified using the corporate number and state in which incorporated. If a partnership, please attach a legible copy of the partnership agreement.

1. “Legal name” means the name listed with the Internal Revenue Service (IRS).
2. “Business name” means the name of the applicant or provider if different from that listed in number 1. If this is a fictitious business name, provide the Fictitious Business Name Statement number and effective date. Attach a legible copy of the recorded/stamped Fictitious Business Name Statement to the application.
3. “Business telephone number” means the primary business telephone number used at the business address. A beeper number, answering service, pager, facsimile machine, biller or billing service, or answering machine shall not be used as the primary business telephone.
4. “Business address” means the actual business location including the street name and number, room or suite number or letter, city, county, state, and nine-digit ZIP code. A post office box or commercial box is not acceptable.
5. “Pay to address” means the address to which payment will be mailed and should include, as applicable, the post office box number, street number and name, room or suite number or letter, city, state, and nine-digit ZIP code.
6. “Mailing address” means where the applicant or provider wishes to receive general Medi-Cal correspondence, if different from the business address. General Medi-Cal correspondence includes bulletin updates and Provider Manual updates.
7. Enter the Federal Employer Identification number (FEIN) issued by the IRS under the name of the applicant or provider. Attach a legible copy of the IRS Form 941, Form 8109 C, Form 147 C, Form SS 4 (Confirmation Notification), or Form 2363.
8. If the business is a sole proprietorship not using a FEIN, provide the social security number or Individual Taxpayer Identification number (ITIN) of the sole proprietor. Attach a legible copy of the ITIN verification, if applicable.
9. Insert the California State Board of Pharmacy Permit number. (Attach a legible copy of the permit.)
10. Insert the applicant’s or provider’s Medicare Billing number.
11. Insert the applicant’s or provider’s Seller’s Permit number issued by the State Board of Equalization. Attach a legible copy of the seller’s permit.
12. List any local business license/permit numbers. Attach a legible copy(ies) to the application.
13. List the days and hours of operation.

14. If applicant or provider intends to bill the Medi-Cal program for durable medical equipment, complete this question by providing the following information:
    - Whether the applicant or provider does or does not have a retail business open to the public that meets all local laws and ordinances regarding business licensing and operations.
    - If this is not a retail business open to the public, explain why.
    - Whether the applicant engages in the sale, rental, and/or lease of items either in stock on the premises or in a warehouse under the applicant's direct control.
    - If the sales of items are of items housed in a warehouse under the applicant's or provider's direct control, provide the address of the warehouse.
    - The name(s), address(es), and telephone number(s) of who holds an ownership interest in the warehouse. Use additional sheets if necessary.
15. Check the applicable business activities of the applicant or provider and give the percentage of those activities. Attach copies of all applicable licenses and/or certifications. Total the percentages. The percentages must total 100 percent. Calculate percentages based upon total dollar sales, including Medi-Cal, Medicare, all other third party payors, and cash transactions for the year immediately preceding filing of this application. If a change of 20 percent or more in total business activity is anticipated within the next year, compared to business activity in the year immediately preceding the filing of this Application, adjust the percentage listings to reflect this anticipated change.
16. Provide the first, middle, and last name of the pharmacist-in-charge at the business location.
17. Provide the license number of the pharmacist-in-charge. Attach a legible copy of the license.
18. Provide the driver's license or state-issued identification number and the state of issuance of the pharmacist-in-charge listed in number 16. Attach a legible copy to this application. The driver's license or state-issued identification number shall be issued within the 50 United States or the District of Columbia.
19. Provide the social security number of the pharmacist-in-charge listed in number 16. (***Optional***—see Privacy Statement on page 3.)
20. "Printed name of the individual signing the application." Enter the last, first, and, middle name of an individual acting on behalf of and with the authority to legally bind the applicant or provider as the sole proprietor, partner, corporate officer or government official when applying to the Department of Health Services for enrollment or continued enrollment as a provider in the Medi-Cal program.
21. List the gender of the individual in number 20.
22. Provide the driver's license or state-issued identification number and the state of issuance of the individual listed in number 20. Attach a legible copy to this application.
23. List the date of birth of the individual in number 20.
24. Provide the social security number of the individual listed in number 20. (***Optional***—see Privacy Statement on page 3.)
25. An original signature of the individual named in number 20 is required. Also provide the title of the person signing the application. Include the city, state, and the date where and when the application was signed.

✓ Remember to attach a legible copy of the following, if applicable:

- ❒ Fictitious Business Name Statement
- ❒ FEIN or ITIN verification
- ❒ Seller's Permit
- ❒ Licenses and certificates associated with business activities (as applicable):
    - ❒ Drug Enforcement Agency Controlled Substance Registration Certificate
    - ❒ California State Board of Pharmacy Permit
    - ❒ Bureau of Home Furnishings and Thermal Insulation License
- ❒ Driver's license or state-issued ID card for the pharmacist-in-charge
- ❒ Pharmacist-in-charge license
- ❒ Driver's license or state-issued ID card for the individual signing the application